Don't Underestimate the Power of a Denial!
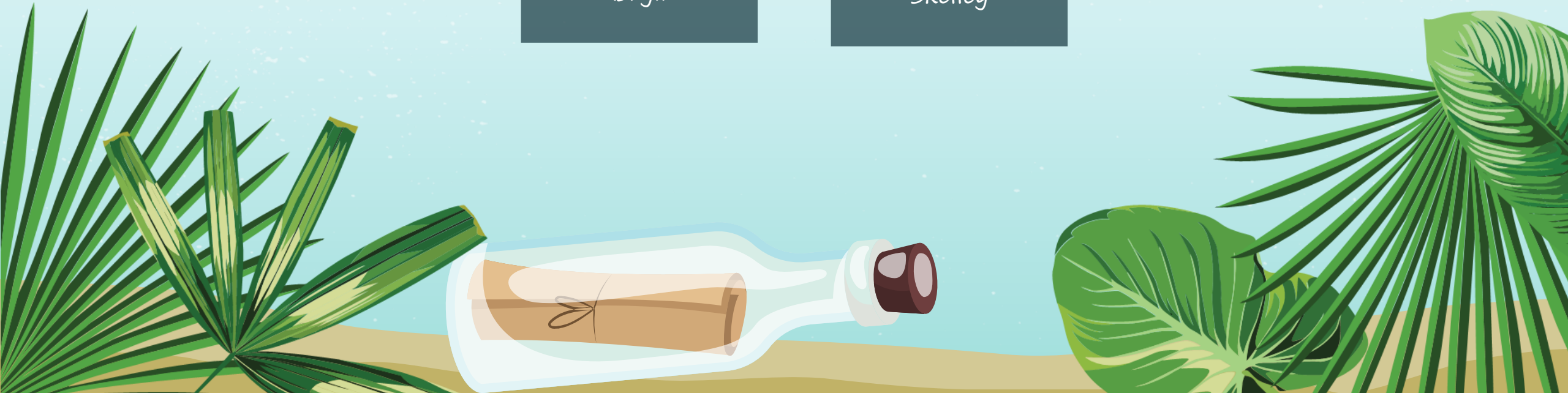
Jean Bryll and Claire Skelley

Presenters

Jean
Bryll

Claire
Skelley

Learning Objectives

✣ RWJBH Denial Management and philosophy

✣ Review what denial reports, KPIs, and analytics processes we use to continually measure performance and impact results

✣ Outline how you can create your own 'Denial Prevention Program' and improve outcomes

Who We Are

RWJBarnabas Health, New Jersey

Vision: Create and sustain healthy communities, together.

12 HOSPITALS	**50+** SPECIALTY CENTERS	**3,000+** PHYSICIANS
4,000+ BEDS	**2m+** OUTPATIENT VISITS	**3m+** PATIENTS

- 47,000+ Employees, Physicians, Residents and Interns

- Trauma Centers

- Integrated Behavioral Health

- Heart, Kidney, and Lung Transplant

- Children's Specialized Pediatric Care
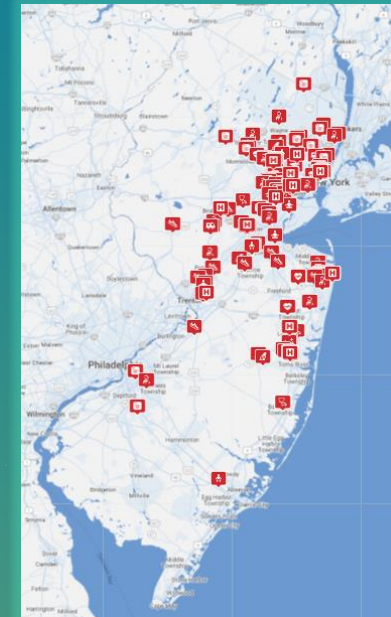
Our Epic Journey

✤ Prior to 2018 all denials and appeals were fully outsourced

✤ 2018 we made the strategic decision to begin insourcing inpatient denials

✤ Goals for insourcing:

➤ Better reporting and root cause understanding

➤ Improved partnership with our internal stakeholders

➤ Expense reduction

✤ We invested a significant amount of time in creating denial reports given multiple data sources, multiple EHRs and vendor reports

✤ Phased Epic conversion schedule – First facility live in October 2021

✤ Epic data is on steroids compared to anything we had before

Agenda

DECIPHERING DENIALS

INVEST IN UNDERSTANDING YOUR DATA

ROOT CAUSE IDENTIFICATION AND TRENDING

PRIORITIZATION OF TOP PROBLEMS AND ENGAGEMENT

Denial Philosophy

Invest in the Process

✤ Go deep into the data to determine what is right for your organization

✤ Before Epic we needed data from multiple sources to create system wide reports for all denials

✤ RWJBH – Insourced appeals for inpatient medical necessity and inpatient no authorization appeals for 7+ years

- Find out what's important and what do you do next
- What are the questions you need answers to
    - *How did I know what data to look at ?*
    - *How did I get from the data to the concussion?*
- Identify the data to tell the story

✤ Identify subject matter experts to identify what is needed

✤ Dedicated team to scrub the data

RWJBH Denial Approach

✤ Identify the top 2-3 areas of opportunity

✤ Review year end $$ to determine each area

✤ Identify key stake holders

✤ Designate will run the reports and distribute them

✤ Assign who will own the meetings and follow up

✤ Identify the top problems

✤ Focus on mitigation and prevention

✤ Create a task force

Denial Reporting

How to get the right data?

Epic data all you need from front end to the back end!

One source with all financial elements

Foundational Data Elements

✤ Identify key trending components:

➤ Trend volume and value month over month

✤ Group Data

➤ Financials, expected reimbursement, total payments, write offs

✤ Each denial category may require different data points

➤ OP No auth – Encounter/Department Specialty, Physician,

➤ IP No auth – Admission source and service type

➤ IP Medical Necessity

☀ *Concurrent wins, loss and outcomes of Peer to Peer*

☀ *DRGS, Length of Stay, Admission source, Discharge disposition*

Report Sample

✤ Reporting is about the Volume and Value and can be tracked by multiple key points such as:

➤ Payer, Root Cause, DRG , LOS, etc.

➤ Account Class IP, OP

➤ Financials to include Expected $, Denied Denials, Total Payments, Denial write off and Account Balance

✤ Report on dates of service or by financials year over year

	Denial Count	Expected Allowed	Denial Amount	Account Balance	Total Payments	Actual Recovery	Write Off Amount
Medical Nec - Full	5,929	$76,892,827	$74,544,706	$42,909,937	($14,128,692)	$7,065,091	$17,064,524
No-Auth	3,338	$34,998,501	$27,606,183	$13,407,601	($16,275,451)	$6,912,353	$1,812,300
Eligibility	3,457	$14,552,066	$12,422,555	$4,913,572	($5,274,097)	$1,399,488	$549,569
Coding	1,823	$16,169,852	$6,399,599	$4,584,156	($11,452,488)	$1,988,556	$502,028
Admin/Other	1,660	$3,273,584	$2,932,303	$582,937	($784,941)	$230,267	$909,568
MR or Missing Forms	672	$2,757,444	$2,669,738	$44,352	($445,082)	$38,241	$1,863,273
Untimely	167	$463,912	$449,697	$8,215	($82,642)	$29,823	$154,992
Grand Total	17,046	$149,108,185	$127,024,782	$66,450,769	($48,443,393)	$17,663,818	$22,856,254

		Denial Count	Expected Allowed	Denial Amount	Account Balance	Total Payments	Actual Recovery	Write Off Amount
2024	Inpatient	6,398	$106,732,429	$96,174,233	$54,701,403	($29,169,501)	$12,381,888	$19,529,277
	Outpatient	9,127	$40,340,982	$28,959,278	$11,137,621	($18,795,072)	$5,179,678	$3,013,569
	Emergency	1,521	$2,034,774	$1,891,271	$611,745	($478,819)	$102,252	$313,408
Grand Total		17,046	$149,108,185	$127,024,782	$66,450,769	($48,443,393)	$17,663,818	$22,856,254

Data Source:
Denials Query in Reporting Workbench

Open, completed, or any?

Any

Bucket types

Primary Claim

Denial Category

Not equal to Informational **AND**
Not equal to Miscellaneous **AND**
Not equal to Duplicate **AND**
Not equal to Missing Claim Information

Resolution Or Response Category

Not equal to Auto Closed-Late Replacement Claim Sent **AND**
Not equal to Auto Closed-Undo Billing Action Performed **AND**
Not equal to Created in Error

- �֍ We worked with Epic to identify elements to include or exclude

- ✤ EOD bucket balance vs account balance would be based on the report

  - ➤ Denials reports will be EOD bucket balance greater than 0
  - ➤ Open act inventory based on act balance greater than 0

- ✤ Root Causes and Denial Category

Epic Denial Fields
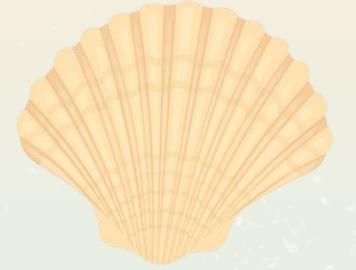
- Updated workflow to add data elements we historically used

- EOD(End of Day) Bucket Balance = Denied amount after 835 hits
  - *Do not rely on denied amount as this is billed charges*
  - *Field name is now called "Balance after Denial Posting"*
  - Appeal Due Date
  - Root Cause
  - Owning User (RN doing appeal)
  - Appeal Strength (based on clinical rational)
  - Appeal Stage
    - *Reconsideration, Level 1 and 2 (Member vs Provider) External (DOBI/Maximus)*

Root Cause

IP Medical Necessity Role Root Causes:

✤ **Full Admission Denials**
✤ **Should Be Observation or Same Day Surgery**
✤ **Medical Necessity- Audit**
✤ **Re Admission and Re admission Audit**

IP No authorization Root Causes:

✤ **Wrong Insurance**
✤ **Payer Issue**
✤ **Change in Patient Status Order – Example: Scheduled SDS (Same Day Surgery changed to Inpatient**
✤ **Primary Exhausted**

OP No authorization Root Causes:

✤ **Authorization Mismatch**
✤ **Units exceeded authorization approved or services go beyond auth dates/units**
✤ **Additional procedures or services performed**

Payer 835 Compared to Confirmed Denial

✤ Payer 835s often do not match the concurrent denial. Including payer terminology

✤ Concurrently denied as not medically appropriate for inpatient services can be rendered in outpatient setting will deny with Denial Reason Code 197 or 39

✤ Identified as not a true denial has increased from 24% to 30% of volume comparing CY 23 to YTD 24

✤ CARC 39 Majority of the time the admission was denied concurrently as services not appropriate for IP

835 vs. Reality

CARC CODE	IT #	2023 $	#	2024 $	Total #	Total $
⊟197-PMT DEN/RDCD, NO PRECERT/AUTH/NOTIF.	872	$11,530,484.54	940	$12,355,639.13	1812	$23,886,123.67
Medical Nec- Full	691	$7,782,341.46	679	$7,352,124.90	1370	$15,134,466.36
No-Auth	168	$3,503,921.43	156	$2,951,408.30	324	$6,455,329.73
Payer Mistake	13	$244,221.65	105	$2,052,105.93	118	$2,296,327.58
Grand Total	872	$11,530,484.54	940	$12,355,639.13	1812	$23,886,123.67

CARC CODE	IT #	$	#	$		
⊟39-SVCS DNIED @ TIME PRECERT/AUTH REQST.	1013	$14,134,707.64	855	$11,346,979.76	1868	$25,481,687.40
Medical Nec- Full	946	$10,796,982.58	743	$9,051,945.30	1689	$19,848,927.88
No-Auth	65	$3,267,372.31	50	$1,011,365.01	115	$4,278,737.32
Payer Mistake	2	$70,352.75	62	$1,283,669.45	64	$1,354,022.20
Grand Total	1013	$14,134,707.64	855	$11,346,979.76	1868	$25,481,687.40

Payer Mistake = Denied on 835 and approval was on file

Opportunity

Identify Areas of Opportunity

✤ Our top 3 challenges and areas of opportunity

  ➢ Inpatient Medical Necessity

  ➢ Patient Status Orders

  ➢ No Authorization

✤ Which stakeholders are needed to address the denials

✤ Payer issues versus internal areas of opportunity for re-education

✤ How can Epic support real time identification via new Workques or patient lists

✤ Evaluate contract language to mitigate denials

✤ Updated workflow to add data elements we historically used

Inpatient Medical Necessity Report Views

Denial Amount by Financial Class

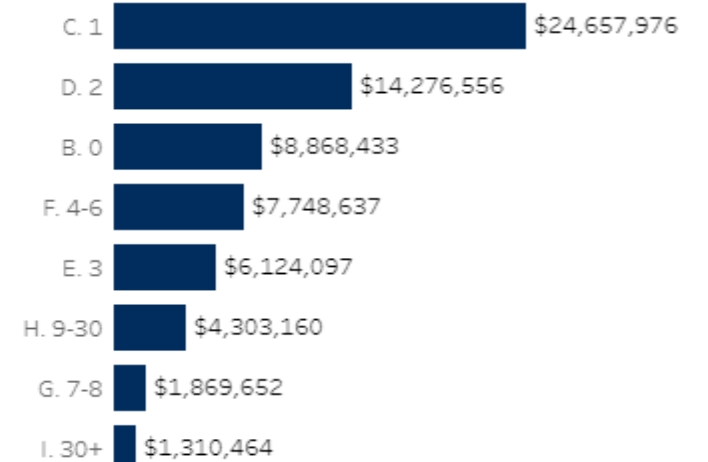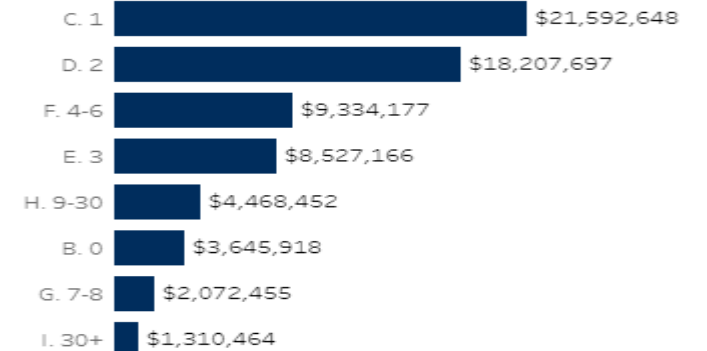| Financial Class	Amount
Medicare Replacement	$23,065,529
Blue Cross	$22,976,626
Managed Care	$12,964,824
Medicaid Replacement	$8,220,994
Medicare	$1,561,506
Commercial	$222,686
Other	$146,810
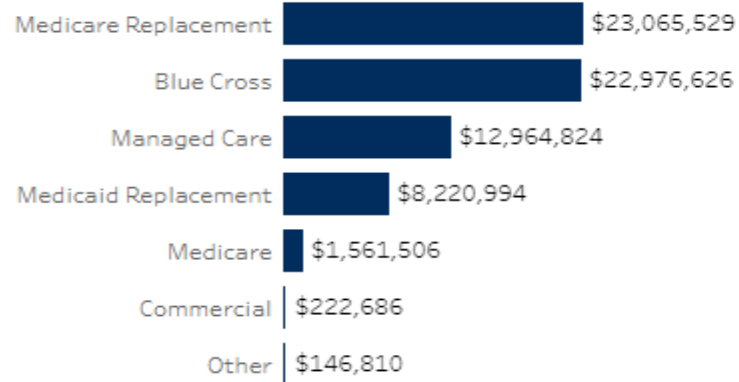
Denial Amount by Bucket Payor

Bucket Payor	Amount
HORIZON BCBS	$22,954,018
AETNA	$8,817,914
AETNA MEDICARE	$8,646,607
UNITED HEALTHCARE MEDICARE	$4,664,792
HORIZON MEDICAID	$3,981,200
AETNA MEDICAID	$2,480,645
UHC COMMUNITY MEDICARE	$2,285,882
CLOVER MEDICARE	$1,959,380
WELLPOINT MEDICARE	$1,669,087
CIGNA	$1,546,069
AMERIHEALTH	$1,315,359
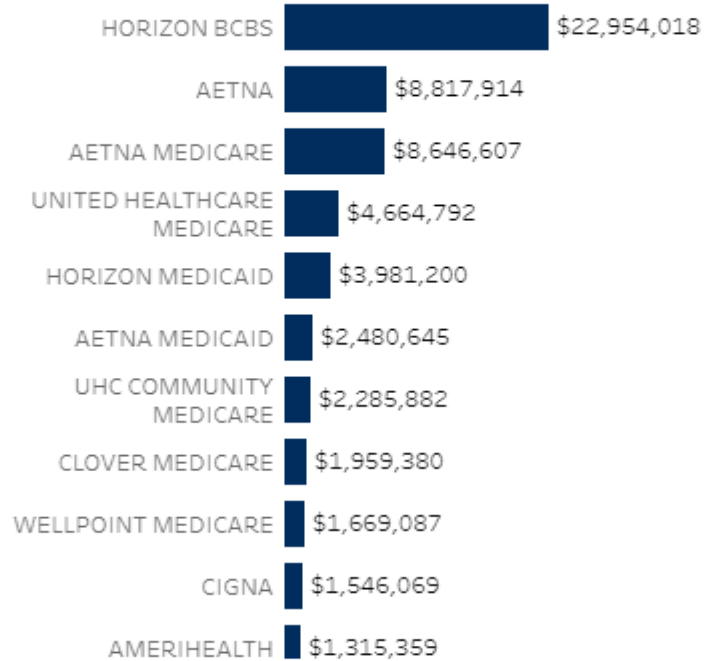
RWJ IP LOS Category

Denial Amount by RWJ IP LOS Category

RWJ IP LOS Category	Amount
C. 1	$24,657,976
D. 2	$14,276,556
B. 0	$8,868,433
F. 4-6	$7,748,637
E. 3	$6,124,097
H. 9-30	$4,303,160
G. 7-8	$1,869,652
I. 30+	$1,310,464

RWJ Admission LOS Category

Denial Amount by RWJ Admission LOS Category

RWJ Admission LOS Category	Amount
C. 1	$21,592,648
D. 2	$18,207,697
F. 4-6	$9,334,177
E. 3	$8,527,166
H. 9-30	$4,468,452
B. 0	$3,645,918
G. 7-8	$2,072,455
I. 30+	$1,310,464

Admission LOS = ED to Discharge (Managed Medicare 2 MN)
Increase of 1M for Managed Medicare that qualifies for 2MN in LOS 2
IP Admission LOS = Based on nights in Bed

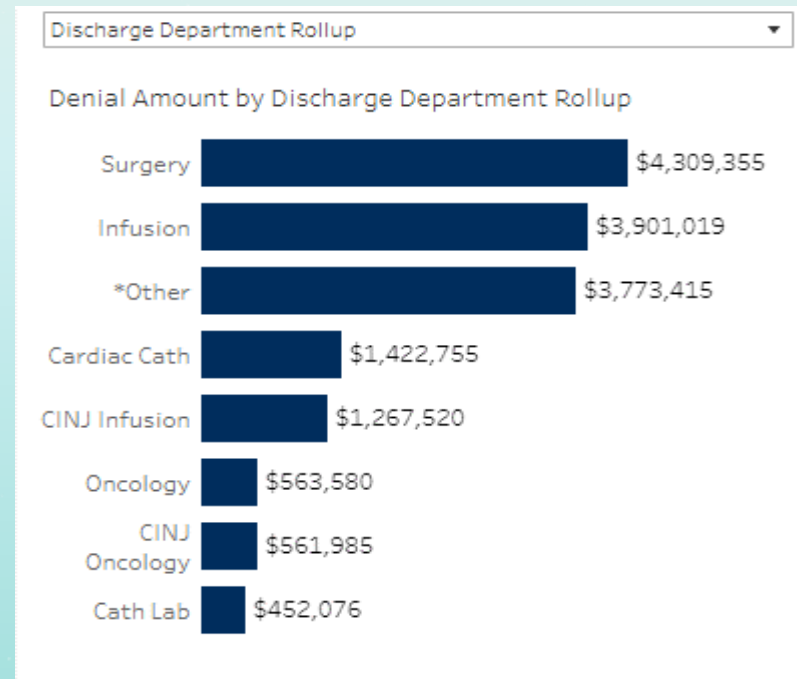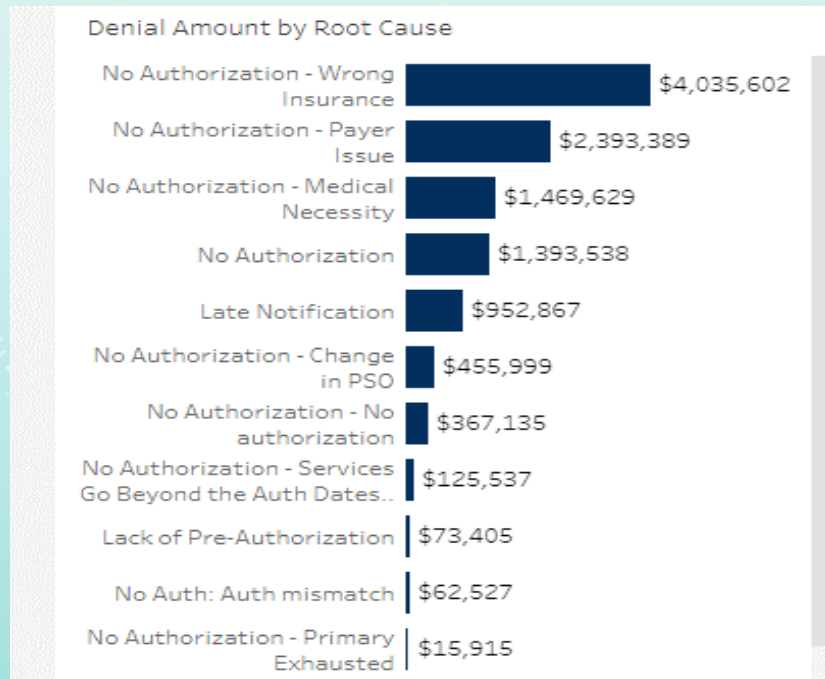# *Process efficiency – Change in PSO)*
Patient Status Order

✤ Identify any area of opportunity to create a workque or patient list in Epic to help identify and reduce denials

❖Increase in Inpatient admission denied as should be done in an OP setting and Late Notification

❖Implemented a PSO (Patient Status Order) process.

❖Created a mismatch WQ Patients scheduled for same-day surgery were flipped to inpatient status.

❖WQ captures patients who have Surgery with an IP Order, scheduled or via ED
  ❖WQ is monitored every few hours
  ❖Work with physicians and case management to ensure we have the correct order
  ❖ Ensured PSO updated to outpatient/observation following surgery

❖Created a flag PSO order validated
  ❖Flag has to be cleared to remove act from Work list
  ❖WQ is not based on Auth cert Status

No Authorization Denials

✤ Report by month over month and yearly trending

✤ Where do you see any reduction and any new denial increases

✤ Trend by payer, date of service and root cause

✤ Inpatient layer in admission type and service type

✤ Outpatient layer in encounter depratments and physician

✤ Work directly with the facility, regional patient access and CFOs

Inpatient No Authorization Denials Report Views

Admission Type	2023 #	2023 $	2024 #	2024 $	Total #	Total $
Emergency	300	$7,712,830.53	332	$7,779,576.33	632	$15,492,406.86
Elective	80	$2,227,482.39	90	$2,073,142.67	170	$4,300,625.06
Urgent	35	$885,519.74	53	$1,289,725.96	88	$2,175,245.70
Newborn	38	$400,832.03	25	$1,213,652.90	63	$1,614,484.93
Trauma Center	6	$115,488.44	11	$168,998.80	17	$284,487.24
Grand Total	459	$11,342,153.13	511	$12,525,096.66	970	$23,867,249.79

Denial Amount by Root Cause

Root Cause	Amount
No Authorization - Wrong Insurance	$4,035,602
No Authorization - Payer Issue	$2,393,389
No Authorization - Medical Necessity	$1,469,629
No Authorization	$1,393,538
Late Notification	$952,867
No Authorization - Change in PSO	$455,999
No Authorization - No authorization	$367,135
No Authorization - Services Go Beyond the Auth Dates..	$125,537
Lack of Pre-Authorization	$73,405
No Auth: Auth mismatch	$62,527
No Authorization - Primary Exhausted	$15,915

Discharge Department Rollup

Denial Amount by Discharge Department Rollup

Department	Amount
Surgery	$4,309,355
Infusion	$3,901,019
*Other	$3,773,415
Cardiac Cath	$1,422,755
CINJ Infusion	$1,267,520
Oncology	$563,580
CINJ Oncology	$561,985
Cath Lab	$452,076

Reporting Process

Report Process

✤ Created workbench reports for each denial report

✤ Developed standard measurements

✤ Created some of our own "Reporting Categories" to simplify trending and analysis

✤ Distribute to appropriate stakeholders (see next slide)

✤ Reports are run on the first of the month and published by the 10th of each month

Task Force and Stakeholders

✤ Create a task force for each area

✤ No Authorization

➤ CFO, facility patient access, regional access, accounts receivable team

➤ Meet weekly with patient access to discuss denials from prior week

✤ Inpatient Medical Necessity

➤ CFO, CMO, Director of Case Mgmt., ED and RDU physician leads

➤ Each month the hospitals review 10 accounts prior to the call that are sent ahead of time

➤ Meeting to discuss overall trending and account specifics

✤ DRG Downgrades

➤ Coding, HIM, CFO

✤ Managed Care Contracting

➤ Contract Language

➤ Specific language- No Authorization and Audits

➤ Denial reporting is used to negotiate contracts

➤ Contacts to escalate issues

✤ Meetings: Monthly with each hospital and then quarterly with the regionals CFO's and managed care contracting team

✤ Legal: Pursue when all else fails!

Area of Opportunity for Managed Care and Legal

✤ Audits

- ➤ Can delay initial cash
- ➤ Admissions are approved concurrently
- ➤ Loose option for P2P

✤ Review your State and Medicare Regulations

- ➤ NJ Medicaid and Medicare ruling:
- ➤ Payer can not retrospectively deny unless you suspect Fraud
- ➤ Contract limitations where applicable
- ➤ Re admits:
- ➤ Check Contract and State Regulations

Appeal Process

- Identify what does and doesn't require a RN

- **Understand the payer process for medical records or payer form prior to formal appeal**

- Appeal the week cases
  - Payers will deny more concurrently if they see you are not appealing
  - Exhaust all appeal efforts
  - DOBI (NJ Medicaid)
  - Maximus(MA Plans)
  - CMS Managed Medicare

- Prioritize appeals

- Appeal due dates

- High Dollar - Denied $50k and greater

- No authorizations

- Use payer websites to upload appeals

- Faxing audits appeals (medical records do not need to be sent again)

In-House Appeals team

- Create Logic based on 835 CARC to move accounts to workques
  - IP, OP, Med Nec, No Auth, Government vs non Government
- Created a "status" that drives accounts to the workque for each step of the process
- Team uses the workque to prioritize the work
  - Appeal due date, aging and $
- Each workque may need different information displayed
  - LOS, DRG, status, root cause

- Team Structure
  - Non-clinical team
    - *Validates denial, enters root cause and appeal due date*
    - *Submit appeals that do not require an RN*
      - Audits, Retro reviews
  - RN do all clinical appeals
    - *RNs with specialties such as Behavioral or NICU*

Active (Total: 116; Amount: 2,326,502.44) Deferred (Total: 0) Completed (Total: 18; Amount: 298,895.92)

Name	Days On Account	WQ	Appeal Due...	Discharge Date	Expected Allowed Amount	Balance	Total Insurance Paym...	Account Number	Invoice Number	Plan

Final thoughts and Take away

✤ Determine your goals and set specific targets

✤ Identify a Task Force or establish a committee

✤ Create reliable reports publish monthly

✤ Monthly meetings to review trending and budget

Wrap-Up

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